CORPORATE INTEGRITY AGREEMENT
GLENN MELTZER, M.D. and MEDICAL EYE CARE SERVICES, P.C.

This Corporate Integrity Agreement (the "Agreement") is entered into between Glenn Meltzer, M.D. and Medical Eye Care Services, P.C. (collectively, the "Providers"), and the Office of Inspector General of the United States Department of Health and Human Service ("OIG").

I. Preamble

Providers agree to implement, at their own cost, the following corporate integrity program and to comply with all Medicare, Medicaid and other federal health care programs' statutes, regulations and program requirements.

II. Corporate Integrity Program

The period of future compliance obligations assumed by Providers under this Agreement shall be five (5) years from the date of full execution of this Agreement. Unless otherwise specified, Providers agree to implement the following measures within forty-five (45) days of the date of full execution of this Agreement:

A. Corporate Compliance Officer

Providers agree to appoint an individual who will carry out the duties of Corporate Compliance Officer to ensure Providers implement and adhere to this Agreement as required herein and to ensure that Providers have met all reporting requirements.

B. Annual Audit

1. For five (5) years from the effective date of this Agreement, Providers agree to implement and to assume the cost of an annual review of claims submitted by Providers and by their agents and employees to the Medicare program to determine that they are medically necessary, and that they are for services that are provided as claimed. The review shall be conducted using a statistically valid sample of claims projectible to the universe. This review shall be performed by an appropriately trained person or entity with sufficient knowledge or experience regarding medical procedures, records, billings and local and national medical policies for the

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services performed and billed by Providers to determine, with regard to each claim reviewed: 1) whether there is a corresponding medical record entry which reflects that the patient named in the claim received the service identified on the claim on the date of service referenced on the claim, and 2) whether the patient's medical record includes a treatment plan or other similar entry which documents the need and purpose of the service provided.

2. Following the review, a report will be prepared and sent to OIG. The report shall list each claim reviewed and shall identify any claims for which the above-referenced determinations could not be made ("deficient claims"). As to any deficient claims, Providers shall, within thirty (30) days of the report, prepare and submit a supplemental report which identifies the remedial steps taken, including where appropriate, the return of any overpayments to the Medicare carrier. The notice to the Medicare carrier should state that the repayment is being made in accordance with the terms of this Agreement and should include: (1) the methodology by which the overpayment was determined; (2) any claims specific information used to determine the overpayment; and (3) the amount of the overpayment. The first report will be due thirteen (13) months after the effective date of this Agreement. Subsequent reviews shall be performed annually from the anniversary date of the submission of the first report. Subsequent reports will be prepared within thirty (30) days of the completion of each annual review.

3. If the Annual Audit is not completed or performed in accordance with the terms of this Agreement, Providers agree to assume the cost of a second review that will be completed in accordance with the terms of this Agreement.

C. **Policies and Procedures**

Providers shall draft and implement policies and procedures to ensure compliance with all Medicare, Medicaid and other federal health care programs' laws, regulations, and policies relevant to Providers' practice. Such policies and procedures shall include, but not be limited to:

1. a policy that will ensure compliance with all Medicare, Medicaid and other federal health care programs' laws, regulations, and policies, including a procedure to obtain guidance from the carrier in

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writing should a question arise about a billing practice;

2. a policy that requires each patient record to be completed the day each patient is seen or within the time frame allowed by Medicare, Medicaid and other federal health care programs' laws, regulations, and policies, with all relevant documentation of patient complaints, examinations given, procedures performed, medical advice given, and any other information that is required in a medical record to support the medical necessity of the procedure(s) and the appropriateness of the procedure codes and diagnosis codes included in the claims; in addition, there will be procedures drafted and followed that will set forth how this will be accomplished; and

3. Toni Meltzer shall not participate in any aspect of coding or billing decisions related to Medicare, Medicaid or other Federal health care programs.

Providers shall distribute these policies and procedures to each employee or any contractor that has responsibility for the management, administration, or billing for Providers. Providers shall also notify OIG at the address set forth in Paragraph IV. within sixty (60) days of the date of full execution of this Agreement, that the policies and procedures have been implemented. Providers shall, upon reasonable notice, make these policies and procedures available for review by OIG at all reasonable times.

D. **Information and Education**

Providers shall send its Office Administrator to one billing or coding seminar annually for at least four (4) hours of training, maintain accurate records of all Providers employees' attendance at billing or coding seminars, and retain any materials disseminated at these seminars.

Providers shall institute and maintain an information and education program designed to ensure that each employee and contractor that has responsibility for the management, administration, or billing for Providers is aware of all applicable Medicare, Medicaid and other Federal health care programs' laws, regulations, and policies. Providers will communicate that failure to comply with its policies and procedures, especially those requiring accurate record keeping and billing, may result in disciplinary action, including termination of employment or the contract.

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Providers shall also post in a conspicuous place in each of its offices a sign that states that if an employee or contractor becomes aware of any practices or billing procedures that the employee or contractor deems to be inappropriate, that employee or contractor should call the Compliance Officer.

Once the Compliance Officer receives a call or complaint, the Compliance Officer shall investigate and, if possible, resolve the complaint. Providers shall make adequate resources available to ensure that the Compliance Officer properly completes the investigations within thirty (30) days. Providers shall ensure that the Compliance Officer retains for six (6) years summary information regarding the general nature of the complaints received and the actions taken to verify and, if applicable, resolve, the complaints. This information shall be retained by Providers in such format so as to ensure that it may be reviewed or reproduced by OIG or its duly authorized representative. The Compliance Officer shall treat as confidential the identity of any employee or contractor placing such a call.

E. **Dealing with Excluded or Convicted Persons or Entities**

Providers shall not employ, with or without pay, or enter into a contract or business relationship with any individual or business entity who:

(1) Providers knows or should have known has been convicted of a criminal offense which would trigger an exclusion pursuant to 42 U.S.C. § 1320a-7(a) or 42 U.S.C. § 1320a-7(b), unless that individual or entity has since been reinstated; or

(2) is listed by a federal agency as currently suspended, debarred, excluded, or otherwise ineligible for federal program participation.

Providers will communicate this policy to all of their employees and to any other entity or individual who has responsibility for the billing. In order to carry out this requirement, Providers agree to make reasonable inquiry into the status of any potential or current employee, agent, or contractor, including review of OIG Cumulative Sanctions Report and the General Services Administration (GSA) List of Parties Excluded from Federal Procurement and Non-Procurement Programs (accessible on the Internet at: http://www/arnet.gov/epls accessible on the OIG's website at http://www.dhhs.gov/progorg/oig/).

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III. **OIG Inspection, Audit and Review Rights**

In addition to any other right that OIG may have by statute, regulation, or contract, pursuant to this paragraph, OIG or its duly authorized representative(s), may examine Providers' books, records, and other documents and supporting materials for the purpose of verifying and evaluating:

1. Providers' compliance with the terms of this Agreement;

2. Providers' business conduct in its dealing with the United States Government, or any agencies or agents thereof; and

3. Providers's compliance with the statutes, regulations and program requirements of the Medicare, medicaid and other Federal health care programs.

Providers shall make the documentation described above available at all reasonable times for inspection, audit, or reproduction by OIG or its duly authorized representative. Providers do not waive, compromise or limit any legally recognized privileges or confidentiality rights under this section.

IV. **Notification**

Unless otherwise stated subsequent to the execution of this Agreement, all notifications and reports required under the terms of this Agreement shall be submitted to the entities listed below:

To OIG:

Civil Recoveries Branch - Compliance Unit
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
330 Independence Ave., SW
Cohen Building, Room 5527
Washington, D.C. 20201
Telephone: 202. 619.2078
Fax: 202.205.0604

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To Providers: Medical Eye Care Services
33 Lincoln Street
Worcester, Massachusetts 01605
Telephone: 508.757.4160
Fax: 508.757.0627

To Counsel for Providers: Michael Kendall, Esq.
McDermott, Will & Emery
75 State Street
Boston, Massachusetts 02109
Telephone: 617.345.5000
Fax: 617.345.5077

V. **Exclusion for Material Breach**

If OIG determines that Providers are in breach of the terms of this Paragraph, OIG will notify Providers of the alleged breach. Providers will then have forty-five (45) days to demonstrate one of the following: (1) Providers are in full compliance with this Agreement; (2) the alleged material breach has been cured; or (3) the alleged material breach cannot be cured within the forty-five (45) day period, but that (i) Providers have begun to take action to cure the material breach, (ii) Providers are pursuing such action with due diligence, and (iii) Providers have provided to the OIG a reasonable timetable for curing the material breach.

If, after this forty-five (45) period, OIG continues to believe that Providers are still in breach, HHS-OIG may declare Providers in default and commence an administrative proceeding, pursuant to 42 C.F.R. §§ 1001 and 1005, in order to exclude Providers from participation in Medicare, Medicaid, and all other federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) until such time as the breach is cured. The only issues to be decided at such administrative proceeding are: (i) whether Providers were in material breach of this Agreement; (ii) whether such breach was continuing at the time that OIG notified Providers of its intent to exclude; and (iii) in those instances in which the breach could not be cured within forty-five (45) days, whether Providers began to pursue such action with due diligence, in order to cure the breach in accordance with a reasonable timetable.

VI. **Document and Record Retention**

Providers shall maintain for inspection all patients' charts, day sheets, electronic media claims summaries, and mail payment logs relating to Medicare reimbursement, for six (6) years after the date of reimbursement for any given

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claim. Providers shall also maintain for inspection all documents relating to the obligations contained in this Agreement for six (6) years from the date of execution of this Agreement.

VII. **Modifications**

This Agreement may be modified by written consent between the parties to this Agreement.

VIII. **Applicability**

During the five (5) year term of this Agreement, the requirements and obligations set forth in this Agreement shall apply to: (i) Glenn Meltzer, M.D. individually, so long as he is participating in any federal health care program, and (ii) to any successor corporation to Medical Eye Care Services, P.C., including a new company formed by an asset purchase, if the new company employs Glenn Meltzer, M.D.

IN WITNESS WHEREOF, the parties hereto affix their signatures.

FOR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

9/22/98
Date

Lewis Morris
Assistant Inspector General
for Legal Affairs
Office of Counsel to the
Inspector General
Office of Inspector General

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FOR PROVIDERS

9/15/98
Date

Glenn Meltzer, M.D., individually
and on behalf of Medical Eye
Care Services
33 Lincoln Street
Worcester, MA 01605

COUNSEL FOR PROVIDERS

9/16/98
Date

Michael Kendall, Esq.
McDermott, Will & Emery
75 State Street
Boston, MA 02109